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ABSTRACT

The first task in the role delineation for the Physician Assistant (PA) was the verification of the entry level generalist position. Using the verified role delineation and data collected from practicing PAs, the possibility of multiple PA positions was investigated as the second task. Two samples of PAs completed task checklists. Responses of a sample of PAs with several years' experience were studied for evidence of a specialist position. It was decided that there was one PA position and therefore, one role delineation. The remainder of the volume--approximately four-fifths--considers use of the role delineation and describes the role delineation of a PA. A definition is provided, and the topics of supervision, primary care, and appropriate use and limitations of the role delineation are discussed. The description of the role delineation addresses the three areas of competence included in the PA role delineation and the 11 major responsibilities that fall roughly into these three categories. The complete role delineation is provided in outline form and lists those tasks which all PAs should be competent to perform. (A summary statement of the working committee is appended.) (YLB)

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The Development of Standards to Ensure the Competency of Physician Assistants

Volume II of V:

Role Delineation for the Physician Assistant

Final Report
Covers Period of Performance
During
July 1, 1976 - August 14, 1979

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(For other key personnel, see Preface.)

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PREFACE

Participants in all parts of the study described in the five volumes of this report are listed below.

The project staff and their areas of responsibility were:

Name	Responsibility
Donald W. Fisher, Ph.D. Executive Director, AAPA/APAP	Project Director
Mary Jane Crain Research Associate	Assessment of the applicability of the University of Wisconsin's Individual Physician Profile (IPP) program for physician assistants Maintenance of a roster of CME programs for physician assistants Design of a system of CME program accreditation
Jane Faulman, Ph.D. Research Associate	Verification of the role delineation for the entry level generalist position Physician assistant position classification Development of a self-assessment tool

The Project Officer for the study, from the Division of Associated Health Professions, was Louis A. Quatrano, Ph.D.

Secretarial and administrative support was provided by:

Veronica Marshall
Karen Hummer
Linda Geary

The project staff consulted a measurement and evaluation specialist, Dr. Richard C. Cox of Pittsburgh, Pennsylvania, to assist

with the IPP and system of continuing medical education (CME) program accreditation portions of this study. Specifically, Dr. Cox designed a checklist for IPP participants and helped with the analysis and presentation of all IPP checklist results. He also assisted the staff in the development of checklists distributed to physician assistants in attendance at selected CME programs throughout the country. The data from these checklists was used in the development of a system of accreditation of physician assistant oriented CME programs.

The development of a self-assessment tool was placed under the direction of a consultant to the project who is a specialist in test development. This consultant was Ayres D'Costa, Ph.D., Associate Professor of Health Professions Education at The Ohio State University in Columbus, Ohio. Under Dr. D'Costa's guidance, a self-assessment examination for physician assistants was developed. Dr. D'Costa planned and conducted all meetings at which the test specifications for the examination were delineated and test items were prepared and revised. He was responsible for all computer output necessary to the project. He designed an individualized, computer-generated test report which includes respondents' scale scores both numerically and graphically.

In addition to the help of consultants, the project staff also benefited from the special expertise and insight of members of the Evaluation, Working, and Advisory Committees. Each of the committees had a specific role to play in the completion of this study.

The Evaluation Committee worked primarily on the assessment of the applicability of IPP for physician assistants, the design of a system of CME accreditation, and the maintenance of a roster of CME programs. Members of this committee reviewed the data collected about the Individual Physician Profile program, suggested other information to be obtained, and made recommendations regarding the program's applicability for physician assistants. The Evaluation Committee had a major role in the development of instruments, the review of data, and the making of recommendations regarding continuing medical education options and accreditation systems. Also, this committee reviewed the roster format for CME programs.

Members of the Evaluation Committee included educational specialists competent in criterion-referenced measurement, design of instructional materials, evaluation methodology, and clinical simulation. The Academy's Professional and Continuing Education Committee had two representatives serving on the Evaluation Committee. The ten members of the Evaluation Committee were:

Philip G. Bashook, Ed.D.
Chicago, Illinois

Robert J. Blakely
Chicago, Illinois

Sarah M. Dinham, Ph.D.
Tucson, Arizona

Stephen C. Gladhart, Ph.D.
Wichita, Kansas

Thomas R. Godkins, P.A.
Oklahoma City, Oklahoma

Jan L. Hagen, M.S.W.
Baltimore, Maryland

Paul F. Moson, P.A.-C.
Loretto, Pennsylvania

Robert R. Moutrie, Ph.D.
Newark, New Jersey

John E. Ott, M.D.
Washington, D.C.

Paul S. Toth, P.A.-C.
Durham, North Carolina

The seven-member Working Committee worked closely with the project staff in developing the Role Delineation for the Physician Assistant. This document was produced via the accomplishment of two tasks: verification of an earlier role delineation (included in the Curriculum Resource Document project) and determination of a position classification for the physician assistant profession. Members of this committee included practicing physician assistants, physicians (in private practice and hospital settings) who employ physician assistants, faculty of physician assistant training programs, and one representative from the Curriculum Resource Document project. The members of the Working Committee were:

Mack Bonner, Jr., M.D.
New York, New York

Trudy Jo Companiotte, P.A.-C.
Nashville, Tennessee

William E. g. de Alva, M.D.
Denver, Colorado

Carl E. Fasser, P.A.-C.
Houston, Texas

Stephen L. Joyner, P.A.-C.
Ayden, North Carolina

Allan B. Kunkel, M.D.
Cleveland, Ohio

Daniel O. Myhre, P.A.-C.
Spokane, Washington

Representatives from major medical organizations with a significant interest in the physician assistant profession served on an Advisory Committee to review materials and provide input to the staff and the other

two committees for all phases of the study. Representatives from the two other committees for the contract served as liaison members on the Advisory Committee. The members of this committee reviewed and provided advice on data, interim reports, and conclusions and recommendations about the role delineation for the physician assistant, the Individual Physician Profile program, the system of CME program accreditation, and the roster of CME programs for physician assistants. The members of this Advisory Committee were:

Leo S. Bell, M.D., F.A.A.P., F.A.P.H.A.
San Mateo, California
American Academy of Pediatrics

Pearl H. Dunkley, R.N., Ed.D.
Kansas City, Missouri
American Nurses' Association

Carl E. Fasser, P.A.-C.
Houston, Texas
Representative of the Working Committee

Dan P. Fox, P.A.-C.
Oklahoma City, Oklahoma
American Academy of Physician Assistants

Thomas R. Godkins, P.A.
Oklahoma City, Oklahoma
Representative of the Evaluation Committee

Rolf M. Gunnar, M.D., F.A.C.P.
Maywood, Illinois
American Medical Association

J. Rhodes Haverty, M.D.
Atlanta, Georgia
National Commission on Certification of
Physician's Assistants

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Association of Physician Assistant Programs

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American Society of Internal Medicine

Robert E. Jewett, M.D.
Dayton, Ohio
Association of American Medical Colleges

Raymond H. Murray, M.D., F.A.C.P.
East Lansing, Michigan
American College of Physicians

Dan A. Nye, M.D.
Kearney, Nebraska
Federation of State Medical Boards
of the United States

Frederic L. Schoen, M.D.
Indianapolis, Indiana
American Academy of Family Physicians

Daniel R. Thomas*
Chicago, Illinois
American Hospital Association

Harold Zintel, M.D., F.A.C.S.
Chicago, Illinois
American College of Surgeons

Finally, a Test Specifications Committee and a group of item writers helped to develop the self-assessment examination for physician assistants. The members of these groups are listed in the Preface to Volume III, Development of a Self-Assessment Examination for Physician Assistants.

*In May 1979, Thomas Atchison, Ed.D., replaced Daniel Thomas at the American Hospital Association.

ACKNOWLEDGMENTS

I wish to thank the project staff, consultants, and committee members (listed in the Preface) who gave so much of their time and experience. We owe a large debt of gratitude to Louis Quatrano, Ph.D., Margaret Wilson, Ph.D., and Robert Conant, Ph.D., for their contributions, advice, and leadership throughout the project.

Especial thanks, however, goes to those persons who worked as staff on contract activities for a limited period of time, particularly Judy A. Light for her creativity in research design, guidance, perseverance, and dedication to the project and the physician assistant profession during her tenure as project director (1976-1978). Also, professional staff support was provided by Ted Kastelic, Ph.D., and secretarial and administrative staff who worked efficiently and effectively on a variety of contract activities were Laura Friedman and Susan Herre.

The staff for the contract would also like to thank others working in the National Office who took time out of busy schedules to review reports, coordinate activities, and offer suggestions. Such cooperation is appreciated.

A very special thanks goes to members of the physician assistant profession. The willingness of physician assistants to spend long hours completing forms, taking tests, and serving on committees is testimony to the enthusiasm and commitment of these individuals to their profession and its objectives.

Donald W. Fisher, Ph.D.

ABBREVIATIONS

AAPA	American Academy of Physician Assistants
CME	Continuing medical education
CRD	Curriculum Resource Document
ICDA	International Classification of Diseases, Adapted
NBME	National Board of Medical Examiners
PA	Physician assistant
PPC	Practice Profile Checklist
PPC-II	Practice Profile Checklist (II)

ABSTRACT

The Role Delineation for the Physician Assistant (PA) is the product of two endeavors, viz, to (a) verify an initial role delineation, which was for the "entry level generalist" position and (b) establish a position classification, i.e., specify the positions within the profession and develop a role delineation for each position.

Two samples of PAs completed task checklists. The responses of a sample of recent graduates were used in verifying the initial role delineation and in determining whether or not there was an "advanced" position. The responses of the other sample, comprised of PAs with several years' experience, were studied for evidence of "specialist" positions. Relying on both the checklist data and their own expert opinion, the Working Committee concluded that, at this time, there is one PA position (the primary care position) and, thus, one role delineation. A summary statement of their decision is included in the report.

The role delineation serves as a base for other products and programs developed for the profession. Already, a preliminary self-assessment examination, based on the role delineation, has been developed (see Volume III). The role delineation may also provide input to formal training, continuing education, and certification programs.

The role delineation should not be used to limit the tasks a PA may competently perform under physician supervision. Nor should the role delineation be seen as a final document for all time. Potential changes in the PA role dictate that the role delineation be reviewed periodically.

INTRODUCTION

In the 1970s the American Academy of Physician Assistants (AAPA) adopted a policy of periodic recertification as one means of assuring the competency of physician assistants (PAs) in the performance of their professional activities. Eligibility for recertification was to be based upon a program of participatory continuing medical education (CME) as published in the guidelines established by the AAPA for PA continuing medical education.

In order to assure that PAs are performing competently, there must exist a clear definition of those tasks which PAs are expected to be competent to perform. The CME programs would then be designed to provide the needed learning experiences, with the recertification process so structured as to document competency in those tasks. To proceed further, the need became apparent for a role delineation for the physician assistant profession.

A role delineation consists of the major and specific responsibilities a practitioner should be competent to accomplish. Major responsibilities describe broad areas of performance, each conveying one major activity of the role. Together, the major responsibilities encompass all of the tasks included in the role delineation. Specific responsibilities describe the execution of the major responsibilities. Within a major responsibility, the specific responsibilities may consist of single performance statements or they may form a hierarchy of performances, depending upon the number of levels necessary to describe in sufficient detail the fulfillment of the major responsibility.

In describing the components of a role delineation, it is neither practical nor useful to include all of the possible activities of all practitioners. Therefore, the intent of a role delineation is not to impose an upper limit on the activities a practitioner may be allowed to perform, but rather to identify those abilities that are absolutely essential for entering and practicing in a profession.

Perhaps the earliest effort toward defining the tasks which physician assistants should be competent to perform was undertaken by the National Board of Medical Examiners (NBME)[1] in 1971. In assuming responsibility for developing a national certification examination for the Assistant to the Primary Care Physician, the NBME defined four major functions which "the Assistant to the Primary Care Physician should definitely be skilled in performing: data gathering, data analysis, medical and health care procedures, and management and therapy." An extensive list of the specific activities of the practitioner was developed for each of these functions. These lists were then used as the basis for developing the proficiency examination which is presently used to certify physician assistants.

An initial role delineation for physician assistants was developed under a contract which was awarded in 1975 to the American Academy of Physician Assistants in cooperation with the Association of Physician Assistant Programs. The product of that project was the Curriculum

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[1]National Board of Medical Examiners. Roles, functions, and responsibilities of the assistant to the primary care physician. Philadelphia: Author, 1971.

Resource Document (CRD),[1] which was completed in 1976. The CRD contains two volumes: Role Delineation (Volume I) and Curriculum Resource Guide (Volume II). The initial role delineation for physician assistants is described and presented in Volume I of the CRD. Volume II contains suggestions and examples of how the initial role delineation can be used in developing and evaluating curricula for physician assistant training. Volume II also contains resource information on curriculum development activities through a sampling of objectives, learning opportunities, teaching strategies, and methods for assessing student performance.

During the development of the initial role delineation, concern was raised that there might be more than one position within the PA profession, for example, "entry" and "advanced" levels and/or "generalist" and one or more "specialist" positions. Therefore, to connote the possibility of there being multiple positions, the initial role delineation was designated for the "entry level generalist" position; as such, its focus was on the competencies expected of a practitioner just entering the profession. The entry level generalist position served as a reference point to investigating the existence of additional positions.

The current project was undertaken for two purposes: (a) verify the initial role delineation for the entry level generalist position and (b) establish a position classification, i.e., determine whether or not there are any positions other than entry level generalist; if so, a role delineation would be developed for each position.

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[1] American Academy of Physician Assistants. Curriculum resource document. (NTIS No. PB 263912/LLC for Volume I, No. PB 264716/LLC for Volume II) Springfield, VA: U,S. Department of Commerce, National Technical Information Service, 1976.

These two purposes were closely linked. Their accomplishment led to the conclusion that, at this time, there is one position for physician assistants, that is, the primary care position. Therefore, there is one role delineation for all physician assistants.

DEVELOPMENT OF THE ROLE DELINEATION

The project's Working Committee and the project staff worked together to develop the role delineation for the physician assistant. The first task was to verify the role delineation for the entry level generalist position. Then, using the verified role delineation and data collected from practicing PAs, the possibility of multiple PA positions was investigated.

In order to verify the role delineation for the entry level generalist position, the Working Committee determined whether discrepancies between the initial role delineation competencies and actual PA job performance were large enough to require modifying the former. Initial efforts were directed at defining the major responsibilities to be included in the role delineation and at designing a task checklist to discern which on-the-job tasks PAs were actually performing during their first few months of practice. The task checklist data was then used as a guide in defining the specific competencies necessary to fulfill the major responsibilities in the verified role delineation for the entry level generalist position.

To address the question of position classification, a second task checklist was designed. This checklist was completed by two samples of PAs -- the sample who had completed the first checklist and a sample who provided a variety of types of patient care. The data provided by both samples was then studied to reach the decision that there is but one PA position.

The procedures and products generated in developing the role delineation can be described by an input-process-output model. Such a

model is presented in Figure 1. The checklists, respondents, data analysis, and decision making are described below.

Task Checklists

Two task checklists were developed and used. The first task checklist, the Practice Profile Checklist (PPC), was developed by the Working Committee and the project staff. Since the purpose of the project was to verify the role delineation reported in the Curriculum Resource Document (CRD), that document served as a starting point in developing the PPC. Working Committee members added some tasks which were not included in the CRD, and they modified others. To ascertain that the respondents, who were presumed to be filling the entry level generalist position, were not performing "advanced level" or "specialty" activities, tasks to represent the latter positions were included in the PPC.

After pilot testing and final review, the PPC contained 1,323 tasks and 25 items describing the respondents and their practices. Respondents completed the checklist by circling a number next to the tasks they performed in their practice. Two types of response options were included. The first type consisted of a "1" preceding the task, which respondents circled if they performed the task and did not circle if they did not perform it. For the second type of response option, each item was preceded (or followed) by three numbers; respondents circled "1" if they commonly performed the task, "2" if they performed the task only under specific circumstances (i.e., only when supervising physician was unavailable or only in consultation with supervising physician), "3" if they did not perform the task but someone else in the practice did, or they circled nothing if no one in the practice performed the task.

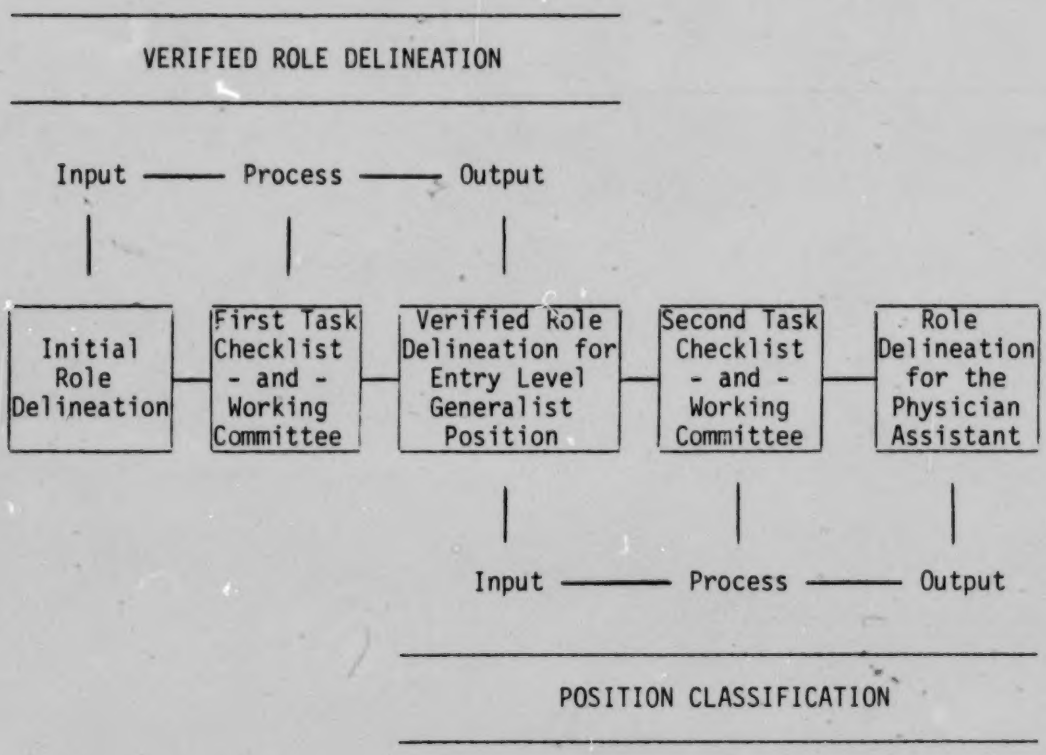

Figure 1. Highlights of the Development of the Role Delineation

Examples of the response options are:

Response	Task
1	Inspect external ear
1 2 3	Perform postural drainage

In the development of the checklists, the two purposes of the project had to be kept in mind. The PPC was to be distributed to a sample of recent graduates to determine what tasks they were performing during their first few months as physician assistants. The project plan called for collecting task checklist data from the same sample approximately one year later to compare the tasks they performed at both times. Therefore, the same tasks must be included in both checklists. Another aspect of the project plan was to collect task checklist data from a second sample of PAs, who had been practicing for several years. Therefore, their checklist must include tasks that practitioners in a variety of specialty positions or levels might perform.

The project staff met with the Working Committee to develop a second task checklist which would meet the requirements of continuity for the first sample and breadth for the second sample. The Practice Profile Checklist (II) (PPC-II) included the PPC tasks as well as tasks that were potentially descriptive of practitioner positions other than the entry level generalist position. The PPC-II had the same response format as the PPC. The PPC-II contained 1,633 tasks and 37 items to describe the respondents and their practices.

Respondents

Two samples of practicing physician assistants completed the task checklists. Sample A consisted of 1976 graduates; this sample completed

both the PPC and the PPC-II. Sample B consisted of PAs who graduated in 1975 or earlier; this sample completed only the PPC-II.

Sample A consisted of 300 recent graduates, selected randomly within each of the 52 accredited physician assistant programs which had a 1976 graduating class. After resampling to replace nonrespondents and those that were ineligible, the final sample resulted in all but eight of the 52 programs being represented by either at least 25% of their graduating class or at least six graduates. One of the smaller programs was markedly underrepresented, with only one graduate in the study. The other seven underrepresented programs had between three and five graduates in the study.

Because participation in the project would require considerable time to complete the checklists, the Sample A members were offered a reimbursement of $30.00 per year for their two-year commitment to participate. In addition to their willingness to make the two-year commitment, invitees were required to be employed as PAs within the United States to be eligible to participate.

Sample A was mailed the PPC in May 1977. The PPC-II was mailed to them in May 1978. Sample A's responses to the PPC were used in verifying the initial role delineation for the entry level generalist position. Their responses to both checklists were compared and studied for evidence of an "advanced level" position.

In addition to "advanced level," another departure from the entry level generalist position would be one or more "specialist" positions. Sample B was chosen to investigate this possibility. Six hundred PAs who had graduated in 1975 or earlier were selected in order to compare which tasks PAs in different specialty areas were performing. Two groups of PAs

were identified as likely to be providing nonprimary care. The two groups were (a) respondents to the most recent PA National Survey who had reported providing nonprimary care and (b) graduates of the nine PA specialty programs which had graduating classes during the prescribed years. All members of these two groups who graduated in 1975 or earlier were sampled. Other PAs selected for Sample B were presumed to be providing primary care. Respondents reported on the PPC-II the type of care they were providing at the time they completed the checklist.

The Sample B invitees were encouraged to look upon completing the PPC-II as a self-assessment exercise. In exchange for their participation, they were granted two hours of Category I CME credit. The two stipulations to participation were that respondents must be providing patient care and must have been in their current practice for at least six months. The PPC-II was mailed to Sample B in July 1978.

Data Analysis

Data analysis consisted of computing the frequency and percentage of respondents who reported performing a task. For the tasks with the 3-option response format, options 1 (commonly performed) and 2 (performed under certain circumstances) were combined in calculating the frequency and percentage who performed the task. In verifying the role delineation for the entry level generalist position, the computations were the responses of Sample A to all of the tasks on the PPC. In determining the number and types of positions within the PA profession, the responses of different groups to specific tasks were compared.

Sample A's responses aided the Working Committee in deciding on whether or not there were both "entry level" and "advanced level" positions. Since most of the tasks on the PPC-II were also on the PPC,

it was possible to compare each individual's, as well as the entire sample's, responses to the same task on both checklists. The group comparisons were made between the percentage of Sample A who reported performing the task on the PPC and the percentage who reported performing it on the PPC-II. Individual's comparisons were made on all of the tasks which had the 3-option response format. Each person's response to the PPC was compared with the response to the PPC-II. From these analyses it was known, for example, the percentage of PAs who "commonly performed" the task during their first few months of practice and one year later and the percentage who "performed a task only when their physician was unavailable" early in their tenure but "commonly performed it" approximately one year later.

To study the possibility of there being more than one "specialist" position, two types of checklist tasks were analyzed: those that appeared on the PPC-II but not on the PPC and "marker" tasks which PAs in a particular specialty were presumed to perform. All respondents to the PPC-II -- i.e., both samples -- were included in the "specialty position" analyses. The respondents reported providing 20 types of patient care; there was also an "other" category. However, many of the categories had very small Ns; eight contained fewer than 10 people. The largest fields were Family Medicine, with 158 PAs, and General Practice Medicine, with 114. The percentage of PAs within each patient care category who performed a task was calculated and compared across the patient care categories.

Decision Making

At the first Working Committee meeting, discussion centered on criteria to use later in deciding whether or not a task was appropriate for inclusion in a role delineation. The Committee felt that such

decisions depended in part on the percentage of PAs performing the task and in part on the criticality of the task to the delivery of health care. Thus, some tasks might be deemed appropriate even though relatively few PAs perform them. No consensus was reached on the required percentage of PAs performing a task to include it in the role delineation; rather, this figure was dependent on the specific task under consideration.

The majority of the Working Committee's decisions were made during their meetings. However, the initial decisions regarding the PPC tasks to include in the role delineation for the entry level generalist position were made via mail. The checklist responses were arranged to allow the seven committee members to individually vote as to whether each task was appropriate or inappropriate for inclusion in the verified role delineation. A tentative decision (subject to group discussion) was reached on the majority of the PPC tasks: 75% of the tasks were tentatively included in the role delineation, 1% were tentatively excluded, and consensus was not reached on 24% of the tasks.

The latter group of tasks was presented to and discussed by the project's Advisory Committee prior to the Working Committee's discussion of the tasks. The Advisory Committee's reasons for thinking a task should or should not be included in the role delineation for the entry level generalist position were recorded by the project staff and provided to the Working Committee to aid in their decisions.

The Working Committee held six meetings. Each meeting was conducted using a combination of nominal group process and guided group discussion. Decisions were made on the basis of consensus or formal vote. At their fifth meeting, the Committee studied the data analyses that were undertaken to suggest whether or not there were multiple positions in the PA profession. After examination of the task checklist data and extensive discussion of

various possibilities, the Committee reached the unanimous decision that, at this time, there is one PA position and, therefore, one role delineation. The position is the primary care position. The activities included in the role delineation are the tasks which PAs must be competent to perform in order to provide quality primary health care.

The members of the Working Committee were very firm in their decision for one position. To express their commitment to their decision, they have included a position paper (prepared by one member of the Committee) with this report. Their position paper is presented as Exhibit A.

To summarize, the methods used to develop the role delineation included developing task checklists, selecting and contacting samples of physician assistants to complete the checklists, analyzing the checklist data, and reaching decisions. Chronologically, the following activities were conducted. The first task checklist was constructed for completion by a sample of recent graduates. Their responses served as an aid in decisions to include or exclude checklist tasks in the verified role delineation for the entry level generalist position. The checklist was later revised to include tasks which PAs in "advanced" or "specialist" positions might perform. The revised checklist was completed by the same sample who completed the first checklist and by a new sample who had been in practice for several years. The responses of both groups were referred to in deciding on the number of positions comprising the physician assistant profession and on the specific tasks which should appear in the subsequent role delineation. Decisions were based on the alternating steps of relying on data to describe "what is" and on expert opinion to describe "what should be." Each step of the method was designed to make the two descriptions compatible.

HOW TO USE THE ROLE DELINEATION

The role delineation is for use with a specific group of health care providers for specific purposes. In order to make clear for whom the role delineation is intended and how it should and should not be used, the following topics are presented below: physician assistant, supervision, primary care, appropriate use, and limitations to use.

The Physician Assistant

The role delineation applies to all physician assistants as defined by the American Academy of Physician Assistants and the Association of Physician Assistant Programs. By their definition, a PA is someone who (a) has graduated from an accredited PA training program and/or (b) has been certified by the National Commission on Certification of Physician's Assistants. (Program accreditation is by the Committee on Allied Health Education and Accreditation of the American Medical Association.) The term "physician assistant" is used generically and includes individuals whose title might be Physician Assistant, Physician Associate, Medex, Child Health Associate, Community Health Medic, Clinical Associate, Primary Care Associate, or, for some, Nurse Practitioner. (Two Family Nurse Practitioner programs are accredited as PA programs, and other eligible nurse practitioners may sit for the certifying exam.)

The American Medical Association's definition of a PA is "a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of the licensed physician

who is responsible for the performance of that assistant."[1] It is generally expected that physicians who employ physician assistants are able to spend more time with complex patient problems which require their time and judgment, while patients with less complex health problems are cared for by the physician assistant with physician supervision.

Supervision

Supervision by a licensed physician is inherent in the PA role. In their review of state legislation regarding PAs, Miller and Byrne[2] found that most states have legislation explicitly prohibiting PA practice without physician supervision; in states where prohibition is not explicit, it is implicit. Miller and Byrne found variation among the states in their definition of supervision. Elements of supervision which states have stipulated in varying formats are: telephone access, written protocols, PA-physician consultation prior to PA's performance of specific tasks, physician review of patient records on a regular basis, limitation on the distance (in miles or minutes) allowed between the PA and physician, and, in remote sites, visitation by the physician on a regular basis. As of 1978, 32 states had placed restrictions on the number of PAs a physician may supervise (one PA per physician in nine states, no more than two PAs in 23 states).

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[1]Todd, M.C. & Foy, D.F. Current status of the physician's assistant and related issues. Journal of the American Medical Association, 1972, 220, 1714-1720.

[2]Miller & Byrne, Inc. Review and analysis of state legislation and reimbursement practices of physician's assistants and nurse practitioners. (Final report of contract no. HRA 230-77-0011, Task Order No. 1.) Department of Health, Education, and Welfare, Public Health Service, National Center for Health Services Research, 1978.

Because the presence of physician supervision is inherent in the role, it is not explicitly stated in the role delineation. However, the user of the role delineation must keep in mind that supervision, in accordance with state legislation and/or practice protocol, is assumed present for each task on the role delineation; the degree of supervision may vary across tasks.

Primary Care

One role delineation is presented for PAs, that is, the role delineation for the primary care PA. Delivery of primary health care has emphasis on a patient's initial contact with the health care system and with the coordination and continuity of care. The following elements are suggested by Silver and McAtee[1] as being aspects of primary care:

- o care of patients in good health and in illness;
- o assessment, diagnosis, and treatment of a wide variety of illnesses, injuries, and surgical and medical emergencies;
- o prevention, recognition, and management of complications;
- o responsibility for provision of patients' total health care needs;
- o provision of psychological and emotional support;
- o counseling and education on family planning, sex, and nutrition;
- o continuing care and management of the chronically ill and disabled;
- o prevention of disease, trauma, and other disorders from environmental hazards;
- o screening for illnesses such as cancer;

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[1]Silver, H.K. & McAtee, P.R. A descriptive definition of the scope of content of primary care. Pediatrics, 1975.

- identification of special risks in patients with congenital and acquired disorders;
- consideration of the determinants of personality, behavior, and disease;
- promotion of patients' capabilities to assume responsibility for their own care; and
- referral of patients as necessary to resources, specialists, and others.

Appropriate Use of the Role Delineation

The role delineation forms a base upon which other professional programs may be built. Regardless of the program, the practitioner is the ultimate recipient of the impact of the role delineation. Others who may use the role delineation include educators, test developers, and potential entrants to the profession.

The role delineation may serve as a guide to educators in the development of both formal training programs and continuing medical education programs. Examples of how to use a role delineation to develop physician assistant program curricula are presented in Volume II: Curriculum Resource Guide of the CRD. Some recommendations for using the role delineation in the development of CME experiences are given in Volume V of this report.

Test developers for the PA profession may rely on the role delineation to develop self-assessment and proficiency examinations. The first self-assessment exam for PAs was based on the role delineation (see Volume III). The next appropriate step in ensuring the competency of PAs is to develop prescriptive learning packages for PAs to aid them in attaining competence in all of the major responsibilities included in the role delineation.

Potential entrants to the PA profession will find the role delineation useful in acquainting them with the competencies they would be expected to develop. The role delineation can provide some preliminary answers to questions such as, "Would I like this profession?" "Do I have an appropriate background to enter this field?"

The above uses of the role delineation have indirect consequences for the practitioner, first, through a formal training program and, later, through CME and formal self-assessment activities. The practitioner can also use the role delineation directly as a self-assessment device. Practitioners can informally monitor their practice behavior and compare their own areas of competence with those included in the role delineation.

Just as the existence of the role delineation has direct implications for educational and certifying agencies, these agencies will also be sensitive to any modifications in the role delineation. Thus, close interactions must continue among training programs, CME programs, certifying bodies, and the AAPA to assure that they share a common perception of the practitioner role.

Limitations of the Role Delineation

A serious concern of all who are involved in developing a role delineation for any position is that it will be misused. It cannot be stressed strongly enough that a role delineation should not be used to limit the activities performed by a practitioner. Some physician assistants will no doubt perform activities that are not included in the role delineation, as specific training or experience may provide them with unique skills. The purpose of a role delineation is merely to specify those tasks which all practitioners in a role must be competent to perform.

THE ROLE DELINEATION SHOULD NOT BE USED TO PREVENT A PRACTITIONER FROM COMPETENTLY PERFORMING A TASK WHICH DOES NOT APPEAR ON THE ROLE DELINEATION.

Another serious concern of role delineation developers is that the role will be seen as defined in perpetuity. Such is not the case. A role delineation is expected to serve the profession for the forseeable future. However, changes will need to be made on the basis of technological improvements alone. Other changes will occur as a result of changes in public opinion, legislation, and medical knowledge. Therefore, this role delineation should be reviewed and reverified periodically.

THE ROLE DELINEATION

Three comprehensive roles or areas of competence are included in the role delineation for the physician assistant. They can be described briefly as follows:

> Professional Role -- the competence necessary to assuming, maintaining, and developing a role identity as a physician assistant
>
> Interpersonal Role -- the competence necessary to effectively communicate with other people
>
> Clinical Role -- the competence necessary to apply medical knowledge and skills to patient problems

Eleven major responsibilities are defined for the competent physician assistant. They fall roughly into the three areas of competence, as shown in Figure 2.

As can be seen in Figure 2, the three PA roles are overlapping. For example, a PA does not perform clinical tasks without also engaging in professional and interpersonal behaviors. The Professional Role and Interpersonal Role competence areas are all-encompassing; each major responsibility in these two areas is interactive with all other major responsibilities in the role delineation. In comparison, the major responsibilities within the Clinical Role area tend to be performed chronologically. The inherent chronology is not rigid, however; in certain cases, some responsibilities might be performed simultaneously (e.g., formulating a plan while analyzing the data base).

The Clinical Role major responsibilities contain considerable detail concerning the patient data to be collected, patient problems to be acted upon, tests to be used, and therapeutic activities to be undertaken. The specific responsibilities which encompass these detailed

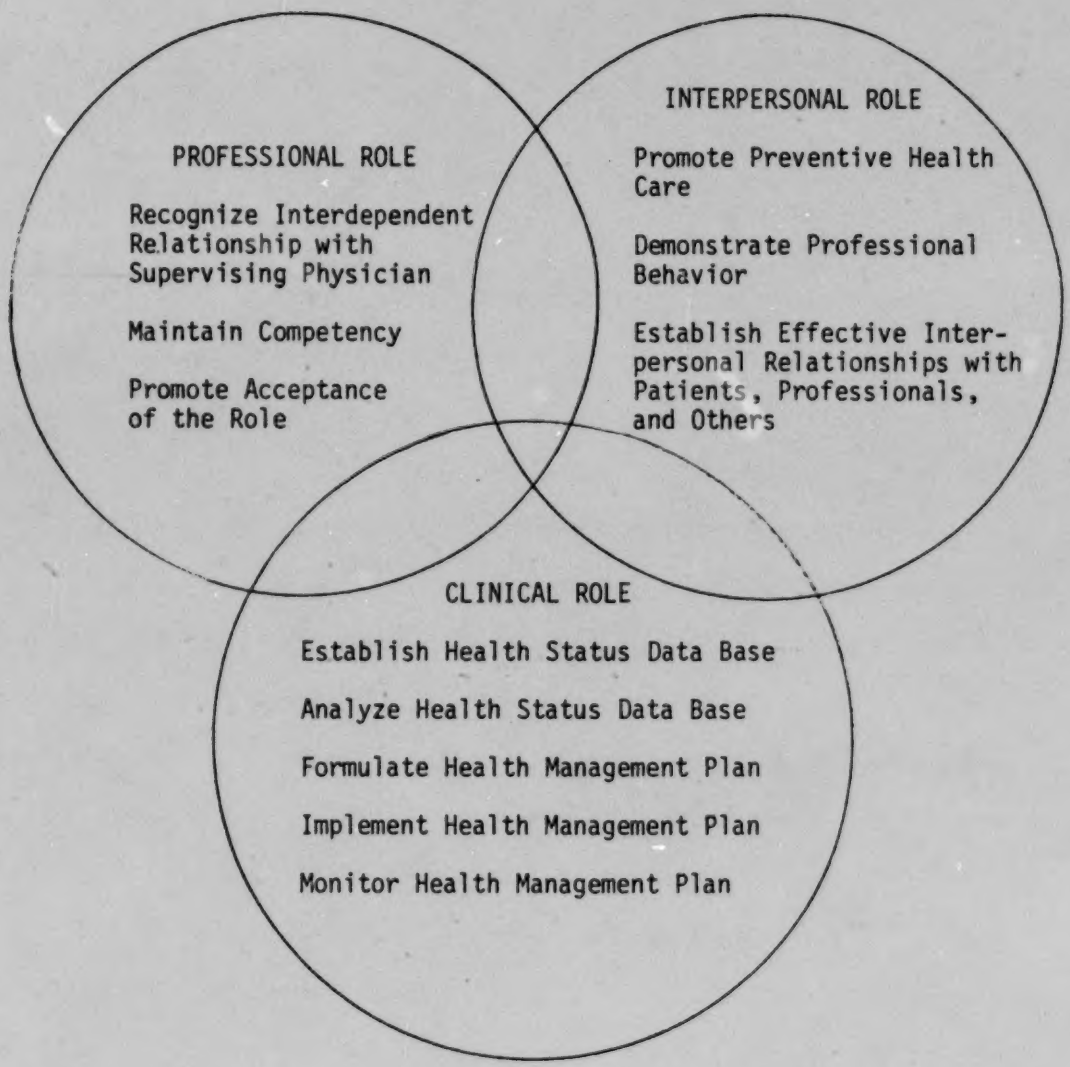
PROFESSIONAL ROLE
Recognize Interdependent Relationship with Supervising Physician
Maintain Competency
Promote Acceptance of the Role
INTERPERSONAL ROLE
Promote Preventive Health Care
Demonstrate Professional Behavior
Establish Effective Interpersonal Relationships with Patients, Professionals, and Others
CLINICAL ROLE
Establish Health Status Data Base
Analyze Health Status Data Base
Formulate Health Management Plan
Implement Health Management Plan
Monitor Health Management Plan

Figure 2. Major Responsibilities within Areas of Competence

tasks are subsumed under the Clinical Role major responsibilities as follows:

VII. Establish Health Status Data Base

- Elicit medical and psychosocial history
- Perform physical examination
- Establish preliminary diagnosis of common problems
- Order screening and diagnostic tests
- Perform screening and diagnostic tests

VIII. Analyze Health Status Data Base

- Interpret raw data from screening and diagnostic tests
- Interpret written report of screening and diagnostic tests
- Validate preliminary diagnosis of common problems
- Establish working diagnosis of common problems

IX. Formulate Health Management Plan

- Formulate a management plan for common problems

X. Implement Health Management Plan

- Provide treatment of common problems
- Initiate medical therapies/procedures

Wherever reasonable, the tasks within a specific responsibility are categorized by body organs or systems. The patient problems and the screening and diagnostic tests are classified according to the International Classification of Diseases, Adapted (ICDA). The classifications used, and their location in the role delineation, are listed in Table 1. The ICDA classification of tests results in some tests appearing in more than one disease category. While this repetition may appear to be unnecessary, it does allow the user to track a disease or symptom from establishing and analyzing the data base through formulating and implementing the management plan.

Table 1: Classifications of Patient Data, Problems, Tests, and Therapies

Patient Data[a]
Take pertinent measurements
Inspect skin, hair, nails
Examine head and neck
Examine eyes
Examine ears
Examine nose and throat
Examine heart and vessels
Examine thorax and lungs
Examine abdomen
Examine genitalia
Examine extremities
Examine nervous system
Examine lymph nodes

Tests[c]
Infectious & Parasitic Diseases/Microbiology
Neoplasms/Oncology
Endocrine, Nutritional & Metabolic Diseases, & Immunity Disorders
Diseases of Blood & Blood-Forming Organs/Hematology
Mental Disorders
Diseases of Nervous System & Sense Organs
Diseases of the Circulatory System
Diseases of the Respiratory System
Diseases of the Digestive System
Diseases of the Genitourinary System
Complications of Pregnancy, Childbirth, and the Puerperium/Obstetrics
Diseases of the Skin & Subcutaneous Tissue/Dermatology
Diseases of Musculoskeletal System & Connective Tissue
Injury & Poisoning

Patient Problems[b]
Infectious & Parasitic Diseases/ Microbiology
Neoplasms/Oncology
Endocrine, Nutritional & Metabolic Diseases, & Immunity Disorders
Diseases of Blood & Blood-Forming Organs/Hematology
Mental Disorders
Diseases of the Nervous System & Sense Organs
Diseases of the Circulatory System
Diseases of the Respiratory System
Diseases of the Digestive System
Diseases of the Genitourinary System
Complications of Pregnancy, Childbirth, and the Puerperium/Obstetrics
Diseases of the Skin & Subcutaneous Tissue/Dermatology
Diseases of Musculoskeletal System & Connective Tissue
Certain Conditions Originating in the Perinatal Period
Symptoms, Signs, & Ill-Defined Conditions
Injury and Poisoning
Factors Influencing Health Status

Therapeutic Activities[d]
Administer Medications
Perform musculoskeletal therapies
Perform pulmonary therapies
Perform eye, ear, nose, and throat therapies
Perform cardiovascular therapies
Perform gastrointestinal therapies
Perform genitourinary therapies
Perform obstetrical/gynecological therapies
Perform surgical procedures
Initiate basic management for emergency situations
Where permitted, prescribe and supervise the use of drugs

Continued on next page.

Footnotes to Table 1

[a]Tasks appear under:
VII. Establish Health Status Data Base
C. Perform physical examination as pertinent

[b]Tasks appear under:
VII. Establish Health Status Data Base
D. Establish preliminary diagnosis of common problems
VIII. Analyze Health Status Data Base
D. Validate preliminary diagnosis of common problems
F. Establish working diagnosis of common problems
IX. Formulate Health Management Plan
G. Formulate a management plan for common problems
X. Implement Health Management Plan
D. Provide treatment of common problems

[c]Tasks appear under:
VII. Establish Health Status Data Base
E. Obtain information from screening and diagnostic tests as pertinent
1. Order screening and diagnostic tests
3. Perform screening and diagnostic tests
VIII. Analyze Health Status Data Base
B. Interpret raw data from screening and diagnostic tests
C. Interpret written report of screening and diagnostic tests

[d]Tasks appear under:
X. Implement Health Management Plan
E. Initiate medical therapies/procedures

As may be noted above, the role delineation contains five activities that might be performed with patient problems and four activities that might be performed with screening or diagnostic tests. The patient problem activities are: establish preliminary diagnosis, validate preliminary diagnosis, establish working diagnosis, formulate plan, and provide treatment. The activities concerning tests are: order, perform, interpret raw data, and interpret written report. However, not all patient problems and tests are listed under all activities. For example, the competent PA should be able to establish and validate a preliminary diagnosis, establish a working diagnosis, formulate a management plan, and provide treatment for cardiac arrest; for angina pectoris, the only requirement is that the PA be competent to establish a preliminary diagnosis.

The complete role delineation for the physician assistant is given below. The tasks listed are those which all physician assistants should be competent to perform. Although the relationship between the physician assistant and the supervising physician is not explicitly stated, implied throughout the document are the stipulations that the physician assistant practice under the responsible supervision of a licensed physician and that the physician assistant carry out only those activities explicitly delegated by the supervising physician. The role delineation should not be used to prohibit the competent performance, within these stipulations, of a task not listed.

ROLE DELINEATION

for the

PHYSICIAN ASSISTANT

I. RECOGNIZE INTERDEPENDENT RELATIONSHIP WITH SUPERVISING PHYSICIAN

A. Accept that the role of the physician assistant is limited by

1. Supervising physician
2. Legislation and regulations
3. Local circumstances
4. Individual's competencies
5. Hospital regulations
6. Patients
7. Other health professions

B. Resist compromises in the practice of medicine when conflicting with professional ethics

C. Express professional opinion on matters of patient care, even if different from supervising physician's opinion

D. Express the limitations of the role when necessary to

1. Supervising physician
2. Other health professionals
3. Patient and family

NOTE: See pp. 14-19 on the use of the role delineation.

II. MAINTAIN COMPETENCY

A. Engage in periodic review of professional skills (self-assessment, etc.)

B. Devise and maintain program of formal and informal CME based upon recognized needs

C. Acquire knowledge and skills essential to incorporating into practice proven new evaluation/treatment modalities

D. Maintain an ongoing library of appropriate journals and books

E. Maintain membership in professional organizations

F. Obtain/maintain certification as a PA

G. Critically review the current literature

NOTE: See pp. 14-19 on the use of the role delineation.

III. PROMOTE ACCEPTANCE OF THE ROLE

A. Explain role by actions and words to others

B. Display sensitivity to the partial overlapping and possible sharing of responsibilities with other health professionals

C. Use formal and informal conflict resolution techniques including adjusting activities, fostering improved working relationships, helping behavior

D. Transmit reference materials to relevant professionals concerning physician assistant functions and utilization

E. Assess within the work group the behavior of individuals and group actions to facilitate problem solving or prevent problems from arising

F. Know and implement strategies useful in gaining acceptance of the role within the community

G. Give talks to groups interested in the PA concept

H. Seek out or counsel prospective PA students

I. Write articles for local newspaper about the PA concept

J. Submit articles for publication

K. Initiate contact with other physicians in the area to promote the PA concept

L. Participate in community health programs

M. Initiate change in routine protocol

NOTE: See pp. 14-19 on the use of the role delineation.

IV. PROMOTE PREVENTIVE HEALTH CARE

A. Educate patient and family concerning health care measures, including

1. Periodic physical examinations
2. Exercise and diet
3. Daily dental hygiene and periodic checkups
4. Regular vision checkups
5. Screening for glaucoma
6. Breast self-examination/Pap smear
7. Warning signs of cancer
8. Use of tobacco, alcohol, other drugs
9. Use of seat belts and child restraints in cars
10. Adequate nutrition
11. Immunizations
12 Accident prevention
13. Poisoning prevention
14. Lead poisoning control
15. Prevention of infections
16. Prevention of cradle cap
17. Prevention of pinworms

B. Perform screening examinations, including

1. Well baby checkups
2. Periodic physical examinations
3. Prenatal examirations
4. Chronic disease checkups (e.g., hypertension, diabetes, obesity, arthritis, etc.)

C. Provide sex education, including

1. Contraception
2. Venereal disease
3. Reproductive process

NOTE: See pp. 14-19 on the use of the role delineation.

IV. PROMOTE PREVENTIVE HEALTH CARE (continued)

D. Provide counseling to patient and family concerning

1. Anxiety reaction
2. Obsessive-compulsive neurosis
3. Depression (nonpsychotic)
4. Maladaptive disorders
5. Marital, divorce, family relationship problems
6. Adjustments to aging
7. Social isolation
8. Development problems of adolescence
9. Behavior problems of children and adults
10. Chronic illness/handicapping conditions
11. Death and dying
12. Psychosomatic illness
13. Mental retardation
14. Sexual problems (e.g., impotency, frigidity, dyspareunia)
15. Alcohol/drug abuse
16. Acute/self-limiting illness
17. Terminal illness

E. Provide resources for patient education

1. Recommend health education pamphlets and books
2. Review films, pamphlets, slide shows, tapes fo selected groups
3. Distribute health literature
4. Use models as resource
5. Use other patients as resource

NOTE: See pp. 14-19 on the use of the role delineation.

V. DEMONSTRATE PROFESSIONAL BEHAVIOR

A. Possess attributes

1. Be empathetic
2. Be objective
3. Recognize personal and professional limitations
4. Develop tolerance in coping with stress of being involved in an emerging profession
5. Develop confidence in professional identity

B. Demonstrate attributes

1. Show respect for the feelings and attitudes of others
2. Maintain patient confidentiality
3. Accept personal and professional limitations
   a. Admit to errors
   b. Accept criticism
   c. Seek continued intellectual growth
4. Persist in effecting constructive change
5. Show patience in dealing with the change process

NOTE: See pp. 14-19 on the use of the role delineation.

VI. ESTABLISH EFFECTIVE INTERPERSONAL RELATIONSHIPS WITH PATIENTS, PROFESSIONALS, AND OTHERS

A. Adapt suitable interviewing style to

1. Enhance communication
2. Elicit relevant medical/psychosocial history
3. Ascertain patient's understanding of historical data
4. Decide on appropriate model/procedures of presenting information
5. Question patients in terms that are appropriate to their level of understanding
6. Clarify clues to other history data
7. Modify interviewing techniques where appropriate
8. Solicit feedback concerning communication
9. Provide feedback concerning communication
10. Determine patient's understanding/acceptance of health problems

B. Accept personal, cultural, and professional factors affecting health

1. Avoid allowing personal beliefs/prejudices to interfere with functions
2. Accept patient's limitations in perceiving health status
3. Accept patient's ability (inability) to comply with therapeutic programs
4. Accept existing uncertainties in the management of personal health
5. Accept and respect feelings and attitudes of others
6. Accept limits of own capabilities and negative feelings of others in case of failure
7. Acknowledge limitations of community resources

C. Assist patient/family in handling/expressing feelings

1. Listen to patient/family discuss personal problems
2. Listen to patient/family express feelings on illness/death
3. Support patient/family in dealing with patient's condition/progress
4. Relate patient's psychological needs to physical condition
5. Encourage patient to ventilate/express feelings

D. Recognize changes in patient's psychological state

1. Observe patient's general appearance and behavior
2. Observe patient for behavior/mood changes
3. Identify factors influencing patient's psychological state

NOTE: See pp. 14-19 on the use of the role delineation.

VI. ESTABLISH EFFECTIVE INTERPERSONAL RELATIONSHIPS WITH PATIENTS, PROFESSIONALS, AND OTHERS (continued)

E. Maintain relationship with referred patients

1. Explain to patient why referral is necessary
2. Continue to monitor referred patient's progress
3. Provide information pertinent to consultation/referral
4. Update patient's record according to referral outcomes

F. Demonstrate concern for patient's privacy, modesty, anxieties during the examination

1. Explain procedures
2. Drape patient appropriately
3. Check on patient's comfort
4. Warm instruments
5. Respond to patient's inquiries
6. Reassure patient during all interactions
7. Use a chaperone

G. Transmit and record information

1. Prepare patient summaries
2. Write accident/incident reports
3. Write progress notes
4. Prepare correspondence
5. Record immunizations on special records
6. Prepare records for clinic (organize history, physical examination, lab data)
7. Perform careful telephone interviews
8. Complete insurance forms

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE

A. Modify data gathering process to take into account

1. Sex of the patient
2. Urgency of the problem
3. Age of the patient
4. Physical condition of the patient
5. Pathophysiology and problem presented
6. Type of examination

a. Problem-specific examination
b. Follow-up physical examination
c. Insurance examination
d. Compensation examination
e. Employment examination
f. School examination
g. Sports examination
h. Postpartem examination

B. Elicit pertinent medical and psychosocial history

1. Elicit chief complaint

a. Statement of complaint in patient's own words
b. Duration of complaint
c. Nature of onset

2. Obtain history of present illness

a. Onset
b. Duration
c. Characteristics
d. Associated symptoms
e. Chronology
f. Prior treatment
g. Factors affecting complaint (e.g., making it better/worse)

3. Obtain past medical history

a. General statement of medical history
b. Childhood diseases
c. Pediatric developmental history
d. Adult illnesses
e. Ob/gyn history
f. Allergies/immunizations
g. Operations/injuries/accidents
h. Medications and compliance
i. Hospitalizations
j. Interval history on chronic diseases
k. Radiological studies

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

B. Elicit pertinent medical and psychosocial history (continued)

4. Obtain relevant family history about parents, grandparents, siblings

a. Health
b. Ages
c. Significant family illness (e.g., diabetes, hypertension, cancer, heart disease, tuberculosis)
d. Cause and age of death
e. Immediate family illness of spouse and children

5. Obtain social history

a. Age
b. Sex
c. Race
d. Domestic state (married, divorced, etc.)
e. Occupation
f. Education
g. Habits (tobacco, alcohol, drugs)
h. Hobbies
i. Present residence
j. Religion
k. Income/source
l. Birth place
m. Travel
n. Military service

6. Review body systems

a. Head
b. Eyes
c. Ears
d. Nose
e. Throat
f. Neck
g. Respiratory
h. Cardiovascular
i. Gastrointestinal
j. Genitourinary
k. Musculoskeletal
l. Neurologic
m. Integument
n. Hematopoietic
o. Endocrine
p. Gynecological
q. Psychiatric

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

C. Perform physical examination as pertinent

1. Take pertinent measurements

a. Measure height and weight
b. Take blood pressure
c. Measure pulse rate (apical and/or peripheral)
d. Take temperature (oral and/or rectal)
e. Measure respiratory rate
f. Take newborn measurements

1. Birth length and weight
2. Frontal occipital circumference
3. Chest circumference
4. Abdominal circumference
5. Anterior fontanel
6. Posterior fontanel

2. Inspect skin, hair, and nails

a. Inspect skin (e.g., for color, texture, turgor, lesions, abrasions, contusions, forcep marks, spots)
b. Inspect nails (e.g., for thickness, color, bands, grooves, curvature)
c. Inspect hair (e.g., for quantity, distribution, quality (texture))

3. Examine head and neck

a. Measure size
b. Determine range of motion
c. Note lymph node enlargement
d. Note thyroid enlargement
e. Note neck vein distention
f. Examine position of trachea
g. Examine carotid pulses and bruits
h. Examine for bossing
i. Examine facial symmetry
j. Inspect thyroid duct remnants
k. Examine for growths, cysts, lesions

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

C. Perform physical examination as pertinent (continued)

4. Examine eyes

a. Test visual acuity
b. Examine conjunctiva, sclera, and cornea
c. Test pupillary reaction to light and accommodation
d. Examine extraocular movements
e. Examine visual fields by confrontation
f. Examine optic discs and retina by fundoscopy
g. Inspect for blind spots
h. Examine eyelid

5. Examine ears

a. Inspect external ear
b. Inspect ear canals, tympanic membranes
c. Test hearing acuity (grossly)
d. Test hearing with tuning fork
e. Perform pneumatoscopy
f. Perform Rinnè and Weber Tests

6. Examine nose and throat

a. Examine mucous membranes (e.g., for inflammation, lesions, pallor)
b. Examine gums and teeth (e.g., for infection, caries)
c. Examine mouth and pharynx (e.g., for lesions, sores, leukoplakia)
d. Note presence of dental prosthesis
e. Examine uvula (e.g., for position, lesions)
f. Perform mirror exam of throat (indirect laryngoscopy)
g. Examine shape of nasal bridge

7. Examine heart and vessels

a. Inspect precordial area for PMI
b. Palpate precordial area for heaves, lifts, thrills
c. Auscultate heart to detect abnormal sounds (e.g., irregularities, murmurs, rubs, gallop rhythms)
d. Palpate peripheral arteries to detect diminished quality
e. Auscultate peripheral arteries for bruits

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

C. Perform physical examination as pertinent (continued)

8. Examine thorax and lungs

a. Inspect thorax for symmetry of movement
b. Palpate for chest wall tenderness and tactile fremitus
c. Percuss chest to detect changes in resonance
d. Auscultate lungs to detect abnormal sounds (e.g., wheezing, rales, rhonchi, diminished breath sounds)
e. Inspect breasts
f. Palpate breasts

9. Examine abdomen

a. Inspect abdomen for collateral circulation, scars
b. Auscultate abdomen for bowel sounds, vascular bruits
c. Palpate abdomen for tenderness, guarding, organ enlargement, masses
d. Percuss abdomen for organ placement, ascites
e. Palpate for inguinal, femoral, ventral hernias
f. Inspect contour and condition of umbilical cord

10. Examine genitalia

a. Inspect external genitalia
b. Perform speculum examination of vagina and cervix
c. Perform bimanual pelvic examination
d. Palpate for height of fundus and position of fetus in pregnancy
e. Perform digital rectal exam
f. Palpate contents of scrotal sac

11. Examine extremities

a. Palpate extremities (e.g., for pulses, edema, varicosities, bone or joint tenderness)
b. Inspect extremities (e.g., for deformity, signs of fractures, swelling)
c. Determine range of motion over joints
d. Inspect and palpate spine for deformity, tenderness
e. Evaluate muscles for strength, size, tone, tenderness
f. Inspect palms and soles of newborn

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

C. Perform physical examination as pertinent (continued)

12. Examine nervous system

a. Test function of cranial nerves
b. Test coordination and cerebellar function
c. Test sensation
d. Test reflexes
e. Evaluate mental status
f. Test for nuchal rigidity
g. Perform newborn neurologic exam

13. Examine lymph nodes

a. Palpate lymph nodes

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

D. Establish preliminary diagnosis of common problems by recognizing the following as a possible diagnosis

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Dermatophytosis
Gastroenteritis (viral)
Gonorrhea (uncomplicated)
Herpes simplex
Herpes zoster (excluding ophthalmicus)
Intestinal parasitic infection
Syphilis (primary)
Tuberculosis (pulmonary)

NEOPLASMS/ONCOLOGY

Malignant neoplastic disease

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Allergy
Dehydration
Diabetes mellitus (adult)
Diabetes mellitus (juvenile)
Failure to thrive
Gout
Hypoglycemia (insulin induced or reactive)
Hypothermia
Hypothyroidism
Obesity
Thyrotoxicosis

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS/HEMATOLOGY

Anemia (adult or pediatric)
Leukemia
Sickle cell disease

MENTAL DISORDERS

Alcoholism
Depression
Drug abuse
Mental health problem (anxiety neurosis, depressive neurosis, obsessive-compulsive neurosis, psychosomatic disorder, situational reactions, social isolation)
Mental retardation

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

D. Establish preliminary diagnosis of common problems by recognizing the following as a possible diagnosis (continued)

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Blindness (recent, acute)
Cataracts
Conjunctivitis
Corneal abrasion (superficial)
Decreased visual acuity
Epilepsy
Glaucoma
Headache (migraine)
Hearing deficit
Iritis
Labyrinthitis
Meningitis
Minimal brain dysfunction
Nystagmus
Otitis externa, otitis media
Speech impairment
Visual/perceptual impairment
Wax in ear

DISEASES OF THE CIRCULATORY SYSTEM

Aneurysm
Angina pectoris
Arteriosclerotic cardiovascular disease (stable)
Bacterial endocarditis
Cardiac arrest
Cardiac arrhythmia
Chest pain of cardiac origin
Congestive heart failure (acute)
Heart murmur
Hemorrhage (internal)
Hemorrhoids (nonsurgical or thrombosed)
Hemorrhoids (surgical)
Hypertension (essential)
Hypertension (secondary, nonsurgical)
Myocardial infarction (acute)
Pericarditis (acute)
Peripheral arterial disease (acute)
Phlebitis, thrombophlebitis
Shock
Transient ischemic attack
Varicose veins (nonsurgical)

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

D. Establish preliminary diagnosis of common problems by recognizing the following as a possible diagnosis (continued)

DISEASES OF THE RESPIRATORY SYSTEM

Adenoidal hypertrophy
Asthma (common)
Asthmatic bronchitis (acute)
Bronchitis (acute or chronic)
Chronic obstructive pulmonary disease
Coryza, febrile cold, influenza-like illness
Cough
Emphysema (with or without bronchitis)
Epistaxis
Influenza
Laryngitis (adult)
Laryngitis (pediatric)
Peritonsillar abscess
Pharyngitis
Pleurisy
Pneumonia
Pneumothorax
Pulmonary edema (acute)
Rhinitis (vasomotor or allergic)
Sinusitis
Tonsillar hypertrophy
Tonsillitis (acute)
Tracheitis (adult)
Tracheitis (pediatric)
Upper respiratory infection

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

D. Establish preliminary diagnosis of common problems by recognizing the following as a possible diagnosis (continued)

DISEASES OF THE DIGESTIVE SYSTEM

Anal fissure
Anal fistula
Appendicitis
Cholecystitis (acute)
Cirrhosis
Colitis (functional)
Constipation
Disease of teeth and supporting structures
Diverticulitis
Gastritis
Gastroenteritis
Hematemesis
Hepatitis
Hiatal hernia (nonsurgical)
Intestinal obstruction
Lower gastrointestinal bleeding (other than hemorrhoids)
Pancreatitis (acute)
Peritonitis
Ulcer (duodenal or gastric)

DISEASES OF THE GENITOURINARY SYSTEM

Amenorrhea, menorrhagia, metrorrhagia
Cervicitis
Cystitis
Glomerulonephritis
Hematuria (female, first episode)
Hematuria (male)
Hydrocele
Kidney stone
Menopausal symptoms
Prostatitis
Pyelonephritis (acute)
Undescended testicle
Urethritis (nonvenereal)
Urinary retention (acute)
Urinary tract infection
Vaginitis
Varicocele
Vulvitis

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

D. Establish a preliminary diagnosis of common problems by recognizing the following as a possible diagnosis (continued)

COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM/OBSTETRICS

Ectopic pregnancy
High risk pregnancy
Preeclampsia
Toxemia
Vaginal bleeding during pregnancy

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

Acne
Carbuncle
Cellulitis
Contact dermatitis
Disease of nail and nail bed
Eczema
Folliculitis
Furuncle
Impetigo
Skin allergy
Urticaria
Wart

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Back pain of musculoskeletal origin
Bursitis
Myalgia
Myositis (inflamed muscle)
Osteoarthritis
Rheumatoid arthritis

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD/NEONATOLGY

Neonatal apnea

SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS

Chest pain of noncardiac origin
Debility or fatigue
Headache (tension)
Weight loss

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

D. Establish a preliminary diagnosis of common problems by recognizing the following as a possible diagnosis (continued)

INJURY AND POISONING

Abrasion (minor)
Burns (first degree)
Contusion (minor)
Drug overdose
Drug reaction (anaphylactic, major)
Drug reaction (non-life-threatening, minor)
Foreign body in orifice
Foreign body not entering through orifice (nonsuperficial)
Foreign body not entering through orifice (superficial)
Fracture (complex)
Fracture (simple)
Frostbite (first degree)
Frostbite (second degree)
Gunshot wound
Insect bite (minor)
Laceration (minor)
Poisoning
Sprain (mild to moderate)
Strain (mild to moderate)
Venomous bite

FACTORS INFLUENCING HEALTH STATUS

Child abuse
Family relationship problems
Sexual problem (e.g., impotence, frigidity, or dyspareunia)
Social problem (economic, educational, employment, housing, or legal)
Smoking

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent

1. Order screening and diagnostic tests

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Antistreptolysin-O titer (ASO)
Blood culture
Chest X-ray
Dark field examination
Febrile agglutinins
KOH (potassium hydroxide) prep
Mononucleosis test
Noncontrast X-ray
Routine specimen plating
Sputum for acid fast bacillus culture
Stool culture
Stool for bacterial stain
Stool for ova and parasites
Tuberculin test
Urine for acid fast bacillus culture
VDRL, RPR, FTA/ABS

NEOPLASMS/ONCOLOGY

Acid phosphatase
Complete blood count
Noncontrast X-ray
Pap smear
Stool for occult blood

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent (continued)

1. Order screening and diagnostic tests (continued)

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Antinuclear antibody (ANA)
Arterial blood gases
Blood sugar
Electrolytes
Glucose tolerance tests
Intradermal testing
Lupus erythematosus prep
Protein electrophoresis
Serum acetone
Skull series
SMA 6/12
Sweat chlorides
T-3, T-4, FTI, TSH
Triglycerides and cholesterol
Uric acid
Urine dipstick test

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS/HEMATOLOGY

B-12
Blood type and cross match
Coomb's test
Folate
Hematocrit
Hemoglobin
Hemoglobin electrophoresis
Iron profile
Partial thromboplastin time
Peripheral blood smear
Prothrombin time
Serum ferritin
Sickle cell prep
Stool for occult blood
White blood count with differential

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent (continued)

1. Order screening and diagnostic tests (continued)

MENTAL DISORDERS

Mental health screening of adults, such as Beck Depression Index, Cornell Medical Index

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Complete blood count
Electroencephalogram
Noncontrast X-ray
Screening audiometry
SMA 6/12
Tonometry
Visual screening with Snellen chart or with Titmus or similar apparatus

DISEASES OF THE CIRCULATORY SYSTEM

Arterial blood gases
Cardiac enzymes
Chest X-ray
Complete blood count
Electrocardiogram
Lipid studies
SMA 6/12
Tourniquet test

DISEASES OF THE RESPIRATORY SYSTEM

Acid fast bacillus stain
Acid fast culture
Arterial blood gases
Chest X-ray
Gram stain of secretions/excretions
Intradermal testing
Noncontrast X-ray
Screening spirometry
Throat culture
Transillumination
White blood count with differential

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent (continued)

1. Order screening and diagnostic tests (continued)

DISEASES OF THE DIGESTIVE SYSTEM

Amylase studies
Anoscopy
Australia antigen
Gram stain of secretions/excretions
Lipase studies
Liver function tests
Noncontrast X-ray
Proctosigmoidoscopy
Protein electrophoresis
Prothrombin time
SMA 6/12
Stool culture
Stool for occult blood
Stool for ova and parasites

DISEASES OF THE GENITOURINARY SYSTEM

Gram stain of secretions/excretions
Noncontrast X-ray
SMA 6/12
Urinalysis
Urinary residual volume
Urine culture
Wet preps or Hanging drop

COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM/OBSTETRICS

Blood type and cross match
Complete blood count
Glucose tolerance tests
Noncontrast X-ray
Pap smear
Pregnancy test
VDRL, RPR, FTA/ABS

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent (continued)

1. Order screening and diagnostic tests (continued)

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

Antinuclear antibody (ANA)
KOH (potassium hydroxide) prep
Lupus erythematosus prep
Patch test

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Antinuclear antibody (ANA)
Complete blood count
Febrile agglutinins
Long bones
Noncontrast X-ray
Rheumatoid arthritis factor
Sedimentation rate
SMA 6/12
Stress X-ray

INJURY AND POISONING

Blood gases
Noncontrast X-ray
SMA 6/12
Urine, blood, and gastric analysis for toxicology

2. Obtain specimens

a. Venous blood
b. Arterial blood
c. Urine
d. Stool
e. Vaginal secretions
f. Tissues
g. Wound
h. Sputum
i. Joint fluid
j. Integumental structures (skin, hair, nails)

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent (continued)

3. Perform screening and diagnostic tests

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Blood culture
Dark field examination
KOH (potassium hydroxide) prep
Mononucleosis test
Routine specimen plating
Tuberculin test

NEOPLASMS/ONCOLOGY

Complete blood count
Pap smear
Stool for occult blood

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Intradermal testing
Serum acetone
Urine dipstick test

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS/HEMATOLOGY

Hematocrit
Hemoglobin
Peripheral blood smear
Stool for occult blood
White blood count with differential

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Complete blood count
Tonometry
Visual screening with Snellen chart or with Titmus or similar apparatus

DISEASES OF THE CIRCULATORY SYSTEM

Complete blood count
Electrocardiogram
Tourniquet test

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent (continued)

3. Perform screening and diagnostic tests (continued)

DISEASES OF THE RESPIRATORY SYSTEM

Gram stain of secretions/excretions
Intradermal testing
Screening spirometry
Throat culture
Transillumination
White blood count with differential

DISEASES OF THE DIGESTIVE SYSTEM

Anoscopy
Gram stain of secretions/excretions
Stool for occult blood

DISEASES OF THE GENITOURINARY SYSTEM

Gram stain of secretions/excretions
Urinalysis
Urinary residual volume
Urine culture
Wet preps or Hanging drop

COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM/OBSTETRICS

Complete blood count
Pap smear
Pregnancy test

NOTE: See pp. 14-19 on the use of the role delineation.

VII. ESTABLISH HEALTH STATUS DATA BASE (continued)

E. Obtain information from screening and diagnostic tests as pertinent (continued)

3. Perform screening and diagnostic tests (continued)

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

KOH (potassium hydroxide) prep
Patch test

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Complete blood count
Sedimentation rate

F. Record and transmit findings

1. Summarize pertinent aspects of history
2. Summarize pertinent aspects of physical examination

G. Inform physician of tentative problem list

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE

A. Differentiate between normal and abnormal (including variations of normal) information obtained in the history and physical examination

1. Differentiate information from the following types of history

   a. Adult history
   b. Child history
   c. Pregnant woman history

2. Differentiate information from the following types of physical examination

   a. Adult physical examination
   b. Child physical examination
   c. Obstetric physical examination
   d. Newborn physical examination

B. Interpret raw data from screening and diagnostic tests

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Chest X-ray
Dark field examination
KOH (potassium hydroxide) prep
Mononucleosis test
Tuberculin test

NEOPLASMS/ONCOLOGY

Complete blood count
Stool for occult blood

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Intradermal testing
Serum acetone
Urine dipstick test

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS/HEMATOLOGY

Hematocrit
Hemoglobin
Peripheral blood smear
Stool for occult blood
White blood count with differential

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

B. Interpret raw data from screening and diagnostic tests (continued)

MENTAL DISORDERS

Mental health screening of adults, such as Beck Depression Index, Cornell Medical Index

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Complete blood count
Visual screening with Snellen chart or with Titmus or similar apparatus

DISEASES OF THE CIRCULATORY SYSTEM

Chest X-ray
Complete blood count
Electrocardiogram
Tourniquet test

DISEASES OF THE RESPIRATORY SYSTEM

Chest X-ray
Gram stain of secretions/excretions
Intradermal testing
Throat culture
Transillumination
White blood count with differential

DISEASES OF THE DIGESTIVE SYSTEM

Anoscopy
Gram stain of secretions/excretions
Stool for occult blood

DISEASES OF THE GENITOURINARY SYSTEM

Gram stain of secretions/excretions
Urinalysis
Urinary residual volume
Wet preps or Hanging drop

COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM/OBSTETRICS

Complete blood count
Pregnancy test

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

B. Interpret raw data from screening and diagnostic tests (continued)

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

KOH (potassium hydroxide) prep
Patch test

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Complete blood count
Sedimentation rate

C. Interpret written report of screening and diagnostic tests

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Antistreptolysin-O titer (ASO)
Blood culture
Chest X-ray
Dark field examination
Febrile agglutinins
KOH (potassium hydroxide) prep
Mononucleosis test
Noncontrast X-ray
Routine specimen plating
Sputum for acid fast bacillus culture
Stool culture
Stool for bacterial stain
Stool for ova and parasites
Tuberculin test
Urine for acid fast bacillus culture
VDRL, RPR, FTA/ABS

NEOPLASMS/ONCOLOGY

Acid phosphatase
Complete blood count
Mammogram
Noncontrast X-ray
Pap smear
Stool for occult blood

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

C. Interpret written report of screening and diagnostic tests (continued)

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Arterial blood gases
Blood sugar
Electrolytes
Glucose tolerance tests
Intradermal testing
Lupus erythematosus prep
Protein electrophoresis
Serum acetone
Skull series
SMA 6/12
Sweat chlorides
Triglycerides and cholesterol
Uric acid
Urine dipstick test

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS/HEMATOLOGY

B-12
Blood type and cross match
Coomb's test
Folate
Hematocrit
Hemoglobin
Hemoglobin electrophoresis
Iron profile
Partial thromboplastin time
Peripheral blood smear
Prothrombin time
Serum ferritin
Sickle cell prep
Stool for occult blood
White blood count with differential

MENTAL DISORDERS

Mental health screening of adults, such as Beck Depression Index, Cornell Medical Index

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

C. Interpret written report of screening and diagnostic tests (continued)

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Complete blood count
Lumbar puncture
Noncontrast X-ray
Screening audiometry
SMA 6/12
Tonometry
Visual screening with Snellen chart or with Titmus or similar apparatus

DISEASES OF THE CIRCULATORY SYSTEM

Arterial blood gases
Cardiac enzymes
Chest X-ray
Complete blood count
Contrast X-ray
Electrocardiogram
Exercise tolerance test
Lipid studies
SMA 6/12
Tourniquet test

DISEASES OF THE RESPIRATORY SYSTEM

Acid fast bacilus stain
Acid fast culture
Arterial blood gases
Chest X-ray
Contrast X-ray
Gram stain of secretions/excretions
Intradermal testing
Noncontrast X-ray
Screening spirometry
Thoracentesis
Throat culture
Transillumination
White blood count with differential

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

C. Interpret written report of screening and diagnostic tests (continued)

DISEASES OF THE DIGESTIVE SYSTEM

Amylase studies
Anoscopy
Australia antigen
Barium enema
Contrast X-ray
Gallbladder series
Gram stain of secretions/excretions
Lipase studies
Noncontrast X-ray
Paracentesis
Proctosigmoidoscopy
Prothrombin time
SMA 6/12
Stool for occult blood
Stool for ova and parasites
Upper gastrointestinal series

DISEASES OF THE GENITOURINARY SYSTEM

Contrast X-ray
Gram stain of secretions/excretions
Intravenous pyelogram
Noncontrast X-ray
SMA 6/12
Urinalysis
Urinary residual volume
Urine culture
Wet preps or Hanging drop

COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM/OBSTETRICS

Amniocentesis
Blood type and cross match
Complete blood count
Culdocentesis
Glucose tolerance tests
Noncontrast X-ray
Pap smear
Pregnancy test
VDRL, RPR, FTA/ABS

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

C. Interpret written report of screening and diagnostic tests (continued)

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

KOH (potassium hydroxide) prep
Lupus erythematosus prep
Patch test

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Arthrocentesis
Complete blood count
Febrile agglutinins
Long bones
Noncontrast X-ray
Rheumatoid arthritis factor
Sedimentation rate
SMA 6/12
Stress X-ray

INJURY AND POISONING

Blood gases
Noncontrast X-ray
SMA 6/12
Urine, blood, and gastric analysis for toxicology

D. Validate preliminary diagnosis of common problems by gathering additional information pertinent to the following

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Dermatophytosis
Gastroenteritis (viral)
Gonorrhea (uncomplicated)
Herpes simplex
Herpes zoster (excluding ophthalmicus)
Intestinal parasitic infection
Syphilis (primary)
Tuberculosis (pulmonary)

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

D. Validate preliminary diagnosis of common problems by gathering additional information pertinent to the following (continued)

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Allergy
Dehydration
Diabetes mellitus (adult)
Diabetes mellitus (juvenile)
Failure to thrive
Gout
Hypoglycemia (insulin induced or reactive)
Hypothermia
Hypothyroidism
Obesity
Thyrotoxicosis

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS/HEMATOLOGY

Anemia (adult or pediatric)
Sickle cell disease

MENTAL DISORDERS

Alcoholism
Depression
Drug abuse

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Cataracts
Conjunctivitis
Corneal abrasion (superficial)
Decreased visual acuity
Glaucoma
Headache (migraine)
Hearing deficit
Iritis
Labyrinthitis
Otitis externa, otitis media
Wax in ear

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

D. Validate preliminary diagnosis of common problems by gathering additional information pertinent to the following (continued)

DISEASES OF THE CIRCULATORY SYSTEM

Cardiac arrest
Chest pain of cardiac origin
Hemorrhoids (nonsurgical or thrombosed)
Hemorrhoids (surgical)
Hypertension (essential)
Hypertension (secondary, nonsurgical)
Myocardial infarction (acute)
Shock
Transient ischemic attack
Varicose veins (nonsurgical)

DISEASES OF THE RESPIRATORY SYSTEM

Adenoidal hypertrophy
Asthma (common)
Asthmatic bronchitis (acute)
Bronchitis (acute or chronic)
Chronic obstructive pulmonary disease
Coryza, febrile cold, influenza-like illness
Cough
Emphysema (with or without bronchitis)
Epistaxis
Influenza
Laryngitis (adult)
Laryngitis (pediatric)
Peritonsillar abscess
Pharyngitis
Pleurisy
Pneumonia
Pneumothorax
Pulmonary edema (acute)
Rhinitis (vasomotor or allergic)
Sinusitis
Tonsillar hypertrophy
Tonsillitis (acute)
Tracheitis (adult)
Tracheitis (pediatric)
Upper respiratory infection

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

D. Validate preliminary diagnosis of common problems by gathering additional information pertinent to the following (continued)

DISEASES OF THE DIGESTIVE SYSTEM

Anal fissure
Anal fistula
Appendicitis
Cholecystitis (acute)
Cirrhosis
Colitis (functional)
Constipation
Diverticulitis
Gastritis
Gastroenteritis
Hematemesis
Hepatitis
Hiatal hernia (nonsurgical)
Intestinal obstruction
Lower gastrointestinal bleeding (other than hemorrhoids)
Pancreatitis (acute)
Ulcer (duodenal or gastric)

DISEASES OF THE GENITOURINARY SYSTEM

Amenorrhea, menorrhagia, metrorrhagia
Cervicitis
Cystitis
Glomerulonephritis
Hematuria (female, first episode)
Hematuria (male)
Hydrocele
Kidney stone
Menopausal symptoms
Prostatitis
Pyelonephritis (acute)
Undescended testicle
Urethritis (nonvenereal)
Urinary retention (acute)
Urinary tract infection
Vaginitis
Varicocele
Vulvitis

COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM/OBSTETRICS

High risk pregnancy

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

D. Validate preliminary diagnosis of common problems by gathering additional information pertinent to the following (continued)

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

Acne
Carbuncle
Cellulitis
Contact dermatitis
Disease of nail and nail bed
Eczema
Folliculitis
Furuncle
Impetigo
Skin allergy
Urticaria
Wart

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Back pain of musculoskeletal origin
Bursitis
Myalgia
Myositis (inflamed muscle)
Osteoarthritis
Rheumatoid arthritis

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD/NEONATOLOGY

Neonatal apnea

SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS

Chest pain of noncardiac origin
Debility or fatigue
Headache (tension)
Weight loss

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

D. Validate preliminary diagnosis of common problems by gathering additional information pertinent to the following (continued)

INJURY AND POISONING

Abrasion (minor)
Burns (first degree)
Contusion (minor)
Drug overdose
Drug reaction (anaphylactic, major)
Drug reaction (non-life-threatening, minor)
Foreign body in orifice
Foreign body not entering through orifice (nonsuperficial)
Foreign body not entering through orifice (superficial)
Fracture (complex)
Fracture (simple)
Frostbite (first degree)
Frostbite (second degree)
Gunshot wound
Insect bite (minor)
Laceration (minor)
Poisoning
Sprain (mild to moderate)
Strain (mild to moderate)
Venomous bite

FACTORS INFLUENCING HEALTH STATUS

Child abuse
Family relationship problems
Sexual problem (e.g., impotence, frigidity, or dyspareunia)
Social problem (economic, educational, employment, housing, or legal)
Smoking

E. Develop diagnostic impressions from information contained in the data base

1. Order more definitive diagnostic tests
2. Consult as needed
3. Formulate tentative diagnostic impressions as a result of

   a. Telephone interviews
   b. Patient's past health records
   c. History gathering
   d. Physical examination
   e. Laboratory tests

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

F. Establish a working diagnosis of common problems based on validation of preliminary diagnosis

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Dermatophytosis
Gastroenteritis (viral)
Gonorrhea (uncomplicated)
Herpes simplex
Herpes zoster (excluding ophthalmicus)
Intestinal parasitic infection
Syphilis (primary)
Tuberculosis (pulmonary)

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Allergy
Dehydration
Diabetes mellitus (adult)
Failure to thrive
Gout
Hypoglycemia (insulin induced or reactive)
Hypothermia
Hypothyroidism
Obesity
Thyrotoxicosis

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS/HEMATOLOGY

Anemia (adult or pediatric)
Sickle cell disease

MENTAL DISORDERS

Alcoholism
Depression
Drug abuse

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

F. Establish a working diagnosis of common problems based on validation of preliminary diagnosis (continued)

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Cataracts
Conjunctivitis
Corneal abrasion (superficial)
Decreased visual acuity
Headache (migraine)
Hearing deficit
Iritis
Labyrinthitis
Otitis externa, otitis media
Wax in ear

DISEASES OF THE CIRCULATORY SYSTEM

Cardiac arrest
Chest pain of cardiac origin
Hemorrhoids (nonsurgical or thrombosed)
Hemorrhoids (surgical)
Hypertension (essential)
Hypertension (secondary, nonsurgical)
Shock
Transient ischemic attack
Varicose veins (nonsurgical)

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

F. Establish a working diagnosis of common problems based on validation of preliminary diagnosis (continued)

DISEASES OF THE RESPIRATORY SYSTEM

Adenoidal hypertrophy
Asthma (common)
Asthmatic bronchitis (acute)
Bronchitis (acute or chronic)
Chronic obstructive pulmonary disease
Coryza, febrile cold, influenza-like illness
Cough
Emphysema (with or without bronchitis)
Epistaxis
Influenza
Laryngitis (adult)
Laryngitis (pediatric)
Peritonsillar abscess
Pharyngitis
Pleurisy
Pneumonia
Pneumothorax
Pulmonary edema (acute)
Rhinitis (vasomotor or allergic)
Sinusitis
Tonsillar hypertrophy
Tonsillitis (acute)
Tracheitis (adult)
Tracheitis (pediatric)
Upper respiratory infection

DISEASES OF THE DIGESTIVE SYSTEM

Anal fissure
Anal fistula
Appendicitis
Cholecystitis (acute)
Cirrhosis
Colitis (functional)
Constipation
Diverticulitis
Gastritis
Gastroenteritis
Hematemesis
Hepatitis
Hiatal hernia (nonsurgical)
Intestinal obstruction
Lower gastrointestinal bleeding (other than hemorrhoids)
Pancreatitis (acute)
Ulcer (duodenal or gastric)

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

F. Establish a working diagnosis of common problems based on validation of preliminary diagnosis (continued)

DISEASES OF THE GENITOURINARY SYSTEM

Amenorrhea, menorrhagia, metrorrhagia
Cervicitis
Cystitis
Hematuria (female, first episode)
Hematuria (male)
Hydrocele
Kidney stone
Menopausal symptoms
Prostatitis
Pyelonephritis (acute)
Urethritis (nonvenereal)
Urinary retention (acute)
Urinary tract infection
Vaginitis
Varicocele
Vulvitis

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

Acne
Carbuncle
Cellulitis
Contact dermatitis
Disease of nail and nail bed
Eczema
Folliculitis
Furuncle
Impetigo
Skin allergy
Urticaria
Wart

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Back pain of musculoskeletal origin
Bursitis
Myalgia
Myositis (inflamed muscle)
Osteoarthritis
Rheumatoid arthritis

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD/ NEONATOLOGY

Neonatal apnea

NOTE: See pp. 14-19 on the use of the role delineation.

VIII. ANALYZE HEALTH STATUS DATA BASE (continued)

F. Establish a working diagnosis of common problems based on validation of preliminary diagnosis (continued)

SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS

Chest pain of noncardiac origin
Debility or fatigue
Headache (tension)
Weight loss

INJURY AND POISONING

Abrasion (minor)
Burns (first degree)
Contusion (minor)
Drug overdose
Drug reaction (anaphylactic, major)
Drug reaction (non-life-threatening, minor)
Foreign body in orifice
Foreign body not entering through orifice (nonsuperficial)
Foreign body not entering through orifice (superficial)
Fracture (complex)
Fracture (simple)
Frostbite (first degree)
Frostbite (second degree)
Gunshot wound
Insect bite (minor)
Laceration (minor)
Poisoning
Sprain (mild to moderate)
Strain (mild to moderate)
Venomous bite

FACTORS INFLUENCING HEALTH STATUS

Child abuse
Family relationship problems
Sexual problem (e.g., impotence, frigidity, or dyspareunia)
Social problem (economic, education, employment, housing, or legal)
Smoking

G. Confer with supervising physician according to practice's guidelines

NOTE: See pp. 14-19 on the use of the role delineation.

IX. FORMULATE HEALTH MANAGEMENT PLAN

A. Resolve deficiencies defined by data base

B. Prioritize problems to be managed

C. Devise plan to coordinate multiple treatment modalities

D. Select therapeutic measures

1. Consider patient's sociocultural environment
2. Consider cost implications of decisions on behalf of the patient

E. Select supportive services to be involved in patient care, to include

1. Supervising physician
2. Patient's family
3. Other health professionals
4. Community resources and services

a. Family planning agencies
b. Mental health agencies
c. Social service agencies
d. Legal services
e. Housing agencies
f. Consumer protection agencies
g. Recreational facilities
h. Visiting nurse
i. Pastoral services
j. School counseling services
k. Religious organizations
l. Community blood banks
m. Red Cross
n. Consulting physician after seeking approval of supervising physician

F. Describe parameters of patient education relating to immediate problems, then others

1. Plan limitation of activities
2. Plan scheduled follow-up

NOTE: See pp. 14-19 on the use of the role delineation.

IX. FORMULATE HEALTH MANAGEMENT PLAN (continued)

G. Formulate a management plan for common problems

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Dermatophytosis
Gastroenteritis (viral)
Gonorrhea (uncomplicated)
Herpes simplex
Herpes zoster (excluding ophthalmicus)
Intestinal parasitic infection
Syphilis (primary)
Tuberculosis (pulmonary)

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Dehydration
Diabetes mellitus (adult)
Gout
Hypoglycemia (insulin induced or reactive)
Hypothermia
Obesity

MENTAL DISORDERS

Alcoholism
Drug abuse

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Blindness (recent, acute)
Conjunctivitis
Corneal abrasion (superficial)
Labyrinthitis
Otitis externa, otitis media
Wax in ear

DISEASES OF THE CIRCULATORY SYSTEM

Arteriosclerotic cardiovascular disease (stable)
Cardiac arrest
Congestive heart failure (acute)
Hemorrhage (internal)
Hemorrhoids (nonsurgical or thrombosed)
Hypertension (essential)
Myocardial infarction (acute)
Shock

NOTE: See pp. 14-19 on the use of the role delineation.

IX. FORMULATE HEALTH MANAGEMENT PLAN (continued)

G. Formulate a management plan for common problems (continued)

DISEASES OF THE RESPIRATORY SYSTEM

Asthma (common)
Bronchitis (acute or chronic)
Coryza, febrile cold, influenza-like illness
Cough
Epistaxis
Influenza
Laryngitis (adult)
Pharyngitis
Pneumonia
Pulmonary edema (acute)
Rhinitis (vasomotor or allergic)
Sinusitis
Tonsillitis (acute)
Tracheitis (adult)
Upper respiratory infection

DISEASES OF THE DIGESTIVE SYSTEM

Anal fissure
Appendicitis
Cholecystitis (acute)
Colitis (functional)
Constipation
Gastritis
Gastroenteritis
Hematemesis
Hiatal hernia (nonsurgical)
Ulcer (duodenal or gastric)

DISEASES OF THE GENITOURINARY SYSTEM

Cystitis
Hematuria (female, first episode)
Prostatitis
Urethritis (nonvenereal)
Urinary retention (acute)
Urinary tract infection
Vaginitis

NOTE: See pp. 14-19 on the use of the role delineation.

IX. FORMULATE HEALTH MANAGEMENT PLAN (continued)

G. Formulate a management plan for common problems (continued)

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

Acne
Carbuncle
Cellulitis
Contact dermatitis
Disease of nail and nail bed
Eczema
Folliculitis
Furuncle
Impetigo
Skin allergy
Urticaria
Wart

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Back pain of musculoskeletal origin
Bursitis
Myalgia
Osteoarthritis

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD/NEONATOLOGY

Neonatal apnea

SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS

Chest pain of noncardiac origin
Debility or fatigue
Headache (tension)

NOTE: See pp. 14-19 on the use of the role delineation.

IX. FORMULATE HEALTH MANAGEMENT PLAN (continued)

G. Formulate a management plan for common problems (continued)

INJURY AND POISONING

Abrasion (minor)
Burns (first degree)
Contusion (minor)
Drug overdose
Drug reaction (anaphylactic, major)
Foreign body in orifice
Foreign body not entering through orifice (superficial)
Fracture (simple)
Frostbite (first degree)
Insect bite (minor)
Laceration (minor)
Poisoning
Sprain (mild to moderate)
Strain (mild to moderate)

FACTORS INFLUENCING HEALTH STATUS

Family relationship problems
Smoking

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN

A. Educate patient and family concerning the following topics

1. Immediate problem(s)

a. Treatment method(s)
b. Activity methods
c. Scheduled follow-up
d. Side effects of treatment
e. Necessity of compliance with care
f. Potential complications of disease(s)
g. Responding to stress

2. Follow-up on deferred problems

3. Home care

a. First aid
b. Administration of medications and injections
c. Use of vaporizer
d. Symptomatic therapy for fever
e. Symptomatic therapy for congestion
f. Symptomatic therapy for diarrhea
g. Symptomatic therapy for constipation
h. Symptomatic therapy for minor aches and pains
i. Symptomatic therapy for nausea and vomiting
j. Pre- and postoperative care

4. Pregnancy

a. Fetal growth
b. Abdominal pains during pregnancy
c. Leg cramps during pregnancy
d. Bleeding and discharge during pregnancy
e. Prepartum and postpartum exercises
f. Peripheral edema during pregnancy

5. Childbirth

a. Early signs of labor
b. Birthing techniques (e.g., Lamaze, LeBoyer)
c. Labor and delivery
d. Breast enlargement postnatally

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

A. Educate patient and family concerning the following topics (continued)

6. Parenthood

a. Teething
b. Growth and development
c. Teenage problems
d. Daycare services
e. Newborn care

1. Feeding
2. Bathing
3. Loving and holding
4. Umbilical cord care
5. Diapering
6. Circumcision care

f. Family planning
g. Genetic counseling
h. Congenital abnormalities and handicapping conditions

B. Contact selected supportive services to be involved in patient care

C. Provide information pertinent to consultation/referral

D. Provide treatment of common problems by carrying out the management plan regardless of who formulated it

INFECTIOUS AND PARASITIC DISEASES/MICROBIOLOGY

Dermatophytosis
Gastroenteritis (viral)
Gonorrhea (uncomplicated)
Herpes simplex
Herpes zoster (excluding ophthalmicus)
Intestinal parasitic infection
Syphilis (primary)
Tuberculosis (pulmonary)

ENDOCRINE DISEASE, NUTRITIONAL AND METABOLIC DISEASES, AND IMMUNITY DISORDERS

Dehydration
Diabetes mellitus (adult)
Gout
Hypoglycemia (insulin induced or reactive)
Hypothermia
Obesity

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

D. Provide treatment of common problems by carrying out the management plan regardless of who formulated it (continued)

DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Conjunctivitis
Corneal abrasion (superficial)
Epilepsy
Headache (migraine)
Labyrinthitis
Otitis externa, otitis media
Wax in ear

DISEASES OF THE CIRCULATORY SYSTEM

Arteriosclerotic cardiovascular disease (stable)
Cardiac arrest
Congestive heart failure (acute)
Hemorrhoids (nonsurgical or thrombosed)
Hypertension (essential)
Hypertension (secondary, nonsurgical)
Shock
Transient ischemic attack

DISEASES OF THE RESPIRATORY SYSTEM

Asthma (common)
Bronchitis (acute or chronic)
Coryza, febrile cold, influenza-like illness
Cough
Epistaxis
Influenza
Laryngitis (adult)
Pharyngitis
Pneumonia
Rhinitis (vasomotor or allergic)
Sinusitis
Tonsillitis (acute)
Tracheitis (adult)
Upper respiratory infection

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

D. Provide treatment of common problems by carrying out the management plan regardless of who formulated it (continued)

DISEASES OF THE DIGESTIVE SYSTEM

Anal fissure
Colitis (functional)
Constipation
Gastritis
Gastroenteritis
Hematemesis
Hiatal hernia (nonsurgical)
Ulcer (duodenal or gastric)

DISEASES OF THE GENITOURINARY SYSTEM

Cystitis
Hematuria (female, first episode)
Prostatitis
Pyelonephritis (acute)
Urethritis (nonvenereal)
Urinary retention (acute)
Urinary tract infection
Vaginitis

DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE/DERMATOLOGY

Acne
Carbuncle
Cellulitis
Contact dermatitis
Eczema
Folliculitis
Furuncle
Impetigo
Skin allergy
Urticaria
Wart

DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Back pain of musculoskeletal origin
Bursitis
Myalgia
Myositis (inflamed muscle)
Osteoarthritis

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

D. Provide treatment of common problems by carrying out the management plan regardless of who formulated it (continued)

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD/NEONATOLOGY

Neonatal apnea

SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS

Chest pain of noncardiac origin
Debility or fatigue
Headache (tension)

INJURY AND POISONING

Abrasion (minor)
Burns (first degree)
Contusion (minor)
Drug overdose
Drug reaction (anaphylactic, major)
Foreign body in orifice
Foreign body not entering through orifice (superficial)
Frostbite (first degree)
Insect bite (minor)
Laceration (minor)
Poisoning
Sprain (mild to moderate)
Strain (mild to moderate)

FACTORS INFLUENCING HEALTH STATUS

Smoking

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

E. Initiate medical therapies/procedures

1. Administer medications of the following types

a. Oral
b. Topical
c. Sublingual
d. Subcutaneous
e. Rectal
f. Inhalation
g. Intravenous
h. Intradermal
i. Intramuscular
j. Intracardiac
k. Vaginal
l. Otologic
m. Ophthalmic

2. Perform musculoskeletal therapies

a. Apply casts
b. Remove casts
c. Reduce dislocated finger/toe (not fractured)
d. Apply splints to extremity
e. Tape joints for increased stabilization
f. Measure and adjust crutches
g. Instruct patient in proper use of crutches
h. Instruct patient about orthopedic exercises
i. Set up and adjust traction
j. Monitor physical therapy

3. Perform pulmonary therapies

a. Teach patients breathing techniques for COPD
b. Assist respiration using positive pressure bag (Ambu bag)
c. Set up oxygen equipment
d. Administer oxygen by nasal cannula and regulate
e. Administer oxygen by venturi mask and regulate
f. Set up and regulate vaporizer and nebulizer
g. Set up and regulate croupette
h. Perform postural drainage
i. Perform artificial respiratory ventilation

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

E. Initiate medical therapies/procedures (continued)

4. Perform eye, ear, nose, and throat therapies

a. Irrigate eye
b. Apply eye patch
c. Perform therapeutic dilatation of pupil
d. Clean ear of impacted wax using irrigation
e. Clean ear of impacted wax using currette
f. Control simple anterior nasal bleeding
g. Pack nose, anterior
h. Suction nose/mouth
i. Suction deep posterior pharynx
j. Suction trachea via tracheostomy
k. Remove and clean inner cannula of tracheostomy
l. Perform indirect laryngoscopy

5. Perform cardiovascular therapies

a. Perform closed chest cardiac massage
b. Apply rotating tourniquets
c. Set defibrillator intensity and discharge
d. Measure central venous pressure
e. Insert intravenous catheter

6. Perform gastrointestinal therapies

a. Give enema
b. Remove fecal impaction
c. Perform gastric lavage
d. Perform stomal care
e. Irrigate gastrostomy
f. Insert nasogastric tube

7. Perform genitourinary therapies

a. Give prostatic massage
b. Perform bladder irrigation
c. Give nephrostomy care
d. Insert urinary catheter (straight or Foley)

8. Perform obstetrical/gynecological therapies

a. Cauterize cervix (chemically)
b. Pack vagina
c. Carry out uncomplicated delivery (without forceps)
d. Administer pudendal block anesthesia
e. Measure for diaphragm
f. Order isolette

NOTE: See pp. 16-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

E. Initiate medical therapies/procedures (continued)

9. Perform surgical procedures

a. Institute appropriate aseptic techniques
b. Institute appropriate isolation techniques
c. Perform wound care
d. Suture minor lacerations
e. Suture surgical incisions
f. Remove sutures
g. Control bleeding/hemorrhage
h. Perform suture line care
i. Cleanse lacerations
j. Debride lacerations
k. Debride burns
l. Insert/remove packing in wounds, incisions, cavities
m. Insert, adjust, remove wound drain
n. Second assist in major surgery
o. Administer digital block anesthesia
p. Administer topical, local anesthesia
q. Biopsy/excise superficial skin lesions, tumors
r. Perform circumcision on infants
s. Apply dry dressing
t. Apply pressure dressing
u. Apply "wet-to-dry" dressing
v. Apply burn dressing
w. Incise and drain subcutaneous abscess
x. Remove subcutaneous foreign body
y. Remove ingrown toenail
z. Remove foreign bodies from nose, ear canal, external eye
aa. Remove wart (surgically)
bb. Remove embedded ticks
cc. Perform cryosurgery for simple skin lesions
dd. Perform chemosurgery for simple skin lesions

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

E. Initiate medical therapies/procedures (continued)

10. Initiate basic management for emergency situations

a. Altered states of consciousness
b. Asthma
c. Bites (animal, fish, human, insect, reptile)
d. Burns (chemical, electrical, thermal)
e. Cardiac arrest
f. Cardiac arrythmias
g. Convulsions
h. Dehydration/volume depletion
i. Diabetic acidosis
j. Dislocations
k. Drowning (near)
l. Drug/chemical ingestion/poisoning
m. Eye injury
n. Fractures
o. Gun shot, stab wounds
p. Head, chest, abdominal injury
q. Heat exhaustion/stroke
r. Hemorrhage (internal)
s. Hypothermia
t. Insulin shock/hypoglycemia
u. Lacerations
v. Myocardial infarction (acute)
w. Neonatal apnea
x. Pneumothorax
y. Precipitous delivery
z. Psychiatric crises
aa. Respiratory impairment/arrest
bb. Severe drug reactions, anaphylaxis
cc. Shock (cardiogenic, hemorrhagic)
dd. Spinal cord injury
ee. Sprains, strains, torn ligaments
ff. Traumatic amputation

NOTE: See pp. 14-19 on the use of the role delineation.

X. IMPLEMENT HEALTH MANAGEMENT PLAN (continued)

E. Initiate medical therapies/procedures (continued)

11. Where permitted, prescribe and supervise the use of drugs

a. Antianxiety medications (minor tranquilizers)
b. Antibiotics
c. Antidepressants
d. Antihistamines
e. Antihypertensives
f. Antispasmodics
g. Contraceptives
h. Digitalis compounds
i. Diuretics
j. Non-narcotic analgesics
k. Sleeping pills
l. Any compounds requiring a BNDD number

NOTE: See pp. 14-19 on the use of the role delineation.

XI. MONITOR HEALTH MANAGEMENT PLAN

A. Assess degree of patient compliance

B. Assess progress toward desired result

C. Determine economic impact of management plan

D. Determine impact of community resources

E. Recognize undesirable effects of treatment plan

F. Redirect patient efforts based upon results of treatment plan

NOTE: See pp. 14-19 on the use of the role delineation.

EXHIBIT A

Summary Statement of the Working Committee
on the

Role Delineation for the
Physician Assistant

SUMMARY STATEMENT OF THE WORKING COMMITTEE

Submitted by William E. g. de Alva, M.D.

on Behalf of the Working Committee

Among the charges met by the Working Committee was to determine whether or not there existed multiple physician assistant positions. The Committee kept in mind that a role delineation in this context described a group of people rather than a single or isolated individual. The role delineation for the physician assistant was defined and established in the earlier part of the Committee's deliberations. In order to recognize different positions for the PA, it was necessary for the Committee to regard the need that each position must incorporate a different set of competencies. It was seen that there would be major implications for the PA profession if, in fact, it was deemed that a variety of roles existed. In such a circumstance there would have to evolve matching criteria for multiple certification and evaluation programs.

The role delineation earlier determined contained all the tasks that practitioners must be competent to perform, while recognizing that the inclusion of a particular task did not necessarily apply to each practitioner performing it with any particular frequency. The role delineation was not deemed to limit the practitioner from performing tasks not included in the role delineation -- that is, the practitioner would be free to develop additional or special skills or to refine to a higher degree of proficiency those that were already in his or her armamentarium.

The Working Committee carefully considered, from the data available, the possibilities that positions such as advanced, radiology, surgery,

pediatrics, emergency room, ophthalmology, industrial medicine, or geriatric existed. Criteria for such specialty positions focused on the notion that such specialists would have skills and ability to perform tasks that others outside of that specialty would not perform or be able to perform.

Philosophically, the Committee had to keep in mind the concern of the PA profession and the health care system at large, the goal being to increase health care delivery at the primary care level to as great a proportion of the population as was possible.

After extensive deliberation and review, the Committee felt there was one position only for the physician assistant profession, i.e., the primary care position. Supporting this conclusion were the following:

> Fragmentation into multiple specialties akin to the fragmentation in the medical profession itself was felt to contribute only to confusion and diffusion of health care delivery.
>
> As a new profession, it was felt the public and consumer deserved clear-cut definitions so as to understand fully the nature of the service and of the provider.
>
> Consolidation of the PA concept and recognition of it as a single entity meets this need better.
>
> There were no data to support clear-cut definitions of more than one position. It was observed that PAs providing different types of patient care did not in fact differ appreciably in the tasks performed from their peers as reflected on the task checklist.

Training of PAs on a broad general basis was considered far more cost effective. On-the-job training would provide for special skills or attributes needed in a particular professional situation. In this regard, it was recognized that situations, even though in allegedly similar type practices, in various cultures and parts of the country

can themselves differ widely and, indeed, require on-the-job "modification" or "molding" of the PA to meet the needs of that setting. As a primary care extender and provider, the PA with a broad background of primary care can and will bring a broader, more comprehensive view to the medical practice served, no matter how finite the specialization of that particular practice.

Before final acceptance of its conclusion, the Committee challenged the single position concept in several ways. The checklists were carefully reviewed for "marker items" which would be performed by PAs of one type position, while not by those of other positions. No such consistent pattern was appreciated. It is not possible to establish a clear pattern of different competencies for allegedly different positions based on the data from the checklist and the responses of the sample study groups.

The Committee concluded its deliberation on this subject with reaffirmation of the principle that there is but one position for the physician assistant profession, that of the primary care position.